[Teresa DeCaro] Hi, everyone.

My name is Teresa DeCaro, and I am the Deputy Director of the State Demonstrations Group in the Center for Medicaid and CHIP Services in CMS. Our group is responsible for Section 1115 Demonstration Authority. I speak for our whole Center about how excited we are to be presenting this webinar. This is the Medicaid and CHIP MAC Learning Collaborative focusing on "Operational Planning for a Section 1115 Reentry Demonstration." It wasn't too long ago that we released a State Medicaid Director's Letter. We'll be going through the major provisions of that, and I have some contextual comments to make.

Then, I'll be turning the rest of the presentation over to Kinda Serafi. I'd like to introduce her. She's a Partner at Manatt Health, who supports CMS in many Medicaid and CHIP coverage learning collaboratives. She brings to this presentation experience working with a number of states on planning, designing, operationalizing their reentry initiatives.

Kindra, we're really excited that you will be leading us through this important learning collaborative.

With that, I think we can go to the agenda, please.

We'll be covering, as I said, the major sections in the State Medicaid Director's Letter. We'll be talking – I will be – on context. Then, you'll be hearing from Kinda on each of the remaining topics here: Medicaid enrollment; eligibility, what populations are eligible; and eligible facilities. Then we'll discuss services including the scope, delivery, and billing and claiming. We'll be going over the reinvestment plan, readiness assessments, implementation plan, monitoring, evaluations. Kinda will be spending time on supporting internal and external partnerships, and also on infrastructure building and the IT system financing.

For each one of these topics, we'll be pausing for questions. We only have a few minutes of questions; and so we'll be taking people's questions and then what we aren't able to get through, we'll be reviewing and would be able to provide some response when the webinar's over.

Next slide, please.

So as I've mentioned, the SMDL Implement Section 5031 of the SUPPORT Act, and that provision directs the U.S. Department of Health and Human Services to issue guidance, which indeed is our State Medicaid Director's Letter, on the 1115 Reentry Demonstration to provide services to justice-involved individuals prior to their release to support their reentry back into the community.

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So here we are, reentry. Historically, states have been unable to draw down Medicaid funding to provide health care services to incarcerated individuals due to restrictions in the federal Medicaid law known as the Inmate Exclusion. So we're going to pause for a moment and just clarify that inmate exclusion. The restriction applies to Medicaid-funded service for inmates in a public institution.

So what is a public institution?

It's a person living in a public institution, and a public institution is defined as an institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control. A correctional institution is considered a public institution and may include state or federal prisons, local jails, detention facilities, or other penal settings, such as boot camps or wilderness camps.

CMS considers an individual of any age to be an inmate if the individual is in custody and held involuntarily through operation of law enforcement authorities in a public institution. Individuals who are held involuntarily in a public institution may be eligible for or enrolled in Medicaid. However, federal Medicaid funds may not be used to pay for services for such individuals while they're incarcerated. The payment exclusion does not apply to inpatients in a medical institution, such as if an inmate is hospitalized or in a nursing home.

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So what are the goals of the Section 1115 Reentry Demonstrations?

It's intended to help state health and correctional systems support reentry of these individuals into the community after leaving incarceration, and there are specific goals. One is to increase coverage, continuity of coverage, and appropriate service uptakes. Another is to improve access to services. Another is to improve coordination and communication. Another is to increase additional investments in health care and related services, and to improve connections between carceral settings and community services.

We're hoping that this demonstration opportunity will reduce all-cause deaths and reduce the number of emergency department visits and inpatient-hospitalizations. Taken together, to say this is we think incredibly important, ambitious, probably quite a challenge to design and put together; and we're all here hoping that you will seriously consider this if you're not already engaging in this work. We look forward to continued working with you even after today's webinar.

Next slide, please.

To date, we have 16 applications for reentry demonstration. Two states – Washington and California – those demonstrations we worked carefully with those states, and they have now been approved; and

they're in an early implementation phase in their design work and what have you. We look forward to the opportunity to work with the other states.

Next slide, please.

So what are the objectives?

The purpose of this presentation is to support states by reviewing the section 1115 Reentry Demonstration features available under the SMDL, and to review requirements and state policy options, and to outline operational considerations to support state implementation planning.

With that -- let's go to the next slide, please -- I welcome Kinda.

Thank you, Kinda.

[Kinda Serafi] Hi, great, thank you so much.

We are *really* so excited that you've agreed to join for an hour and-a-half. What we really want to do, as Teresa laid out, is help you understand what it means to operationalize such an important and ambitious initiative. I think we are on this call because you agreed that this is a really important thing to do for the justice-involved populations.

So what we want to bring to the table is how are you going to do it, and what are the policy questions you're going to ask yourself and the operational issues that – we really want to prepare you as you're going into this. So if you're a state that has a pending waiver in front of -- or an approved waiver or a pending waiver in front of CMS, our goal is to help you understand what's to come next after you get waiver approval. If you are a state that's really seriously thinking about applying for waiver approval from CMS but you really want to know what goes into it and you want eyes wide open, that's also the goals of the discussion.

As Terese laid out, what we're going to go through is we're going to sort of go through each of the 1115 waiver features to implement a reentry initiative and then stop. We're going to let me speak for about 10 minutes, put in the Chat as much questions as you want. Terese is going to facilitate a question and answer after each of the sections. Through each of those sections that Terese went through, we're going to pause. So really want to make sure that this is as engaging as possible because we're here for you to be able to understand what really goes into such a complex but important initiative.

Okay, so with that, let's start off. I'm going to go to the next slide and start with first things first.

The first thing you have to do before you can provide any services to anybody in a reentry initiative is to make sure that they have Medicaid. They *have* to be enrolled in Medicaid. So under the State Medicaid Director Letter -- we're going to sort of shorthand it and call it SMDL, although I hate acronyms -- but let's just say the guidance is really clear that everybody who is eligible for the initiative must first be enrolled in Medicaid. Or if they come into a correctional facility, there needs to be an implementation of suspension. So first, let me just tick through the requirements, and then we'll go through the operational considerations.

So actually predating the initiative, the SUPPORT Act had required that all states have processes in place to have enrollment and suspension for your youth – for your Medicaid-eligible children under age 21. So hopefully you have been, as a Medicaid agency, working with your youth correctional facilities to make sure that this is – that at least sort of we're moving in a direction of this being implemented in all your youth correctional facilities. We'll talk a little bit more about that when you're doing an enrollment about how to assess whether you are or not.

As a threshold matter, we need to have individuals enrolled in Medicaid. So there needs to be a sort of process that's put in place where your correctional facilities are starting an application process, working with various different types of partners that can assist individuals in submitting an application, and doing it within a time frame that is reasonable so that we can effectuate the delivery of pre-release services. The guidance says having that application initiated no later than 45 days before the expected date of release.

The first question you're going to say is, "In some facilities, I don't know the release date." We're going to talk about that in a minute, and we're fully tracking that as an issue. Okay, that's the enrollment requirement. Now let's talk about suspension.

Let's say John Smith comes into the correctional facility already enrolled in Medicaid, or you've enrolled the person in Medicaid and we need to suspend. This a requirement in the guidance. You may not terminate coverage. We do not want to get into a place where someone has to apply for Medicaid *again* when they're leaving the correctional facility and entering the community. That's the whole goal of suspending and not terminating.

We *really* are looking to have a continuity of services both in the pre-release period and then into the post-release period. So it's really, really important. The guidance really understands that states are in various stages with their capacity to implement suspension and has basically said, "We're going to work with you. You can propose an alternate policy and procedure while you're setting up and standing up suspension processes," and gives states up to two years to implement this fully. So that's the sort of threshold set of requirements.

Now let's talk about the operational considerations.

Okay, so you're going to hear a lot of, "Conduct a state assessment." What we mean there is sort of just figure out what's going on in the correctional facilities which you own or work with. There's a number of

ways to do current-state assessments, and throughout the webinar we'll sort of talk about how to do it. A first common way that some state Medicaid agencies have done is they issue a survey with their correctional facility partners. They sort of say, "Tell us about your Medicaid enrollment processes. Are you standardized? When do you do them? How frequently do you do them? Who do you work with to help submit the application?"

So first thing is doing a current-state assessment. You can do it through a survey. You can do it through targeted interviews. Most facilities, if you're working with the prisons, obviously have a head person within your department of corrections or the equivalent for the prison system. For the jails, there could be a sheriff's association or other sort of association that you can work with to help understand Medicaid application processes at the current state, sort of as of today.

It's also really important to assess gaps in processes that are happening in the youth correctional facilities. This has been a requirement that states had to have put into place, but we understand that that's also sort of – we're moving towards getting that to be fully compliant. So it's another way to make sure you're understanding what's currently happening in all your current correctional facilities but also, importantly, in your youth correctional facilities as that's already been a requirement in place.

Then, thinking about what needs to be accommodated to be able to put in new non-termination and suspension processes. So that's sort of like Step 1, is like understanding the lay of the land in your facilities that you want to be working with. Also, it could be this is helping you figure out *what* facilities you want to work with because it may be that you have a set of facilities that are nailing it with just standardized enrollment and suspension processes; in which case, maybe those are the facilities that you start in a Phase 1 if you will.

Okay, so now who can do enrollment for helping people enroll?

That can be a correctional facility worker, a state Medicaid agency eligibility enrollment worker that's out-stationed, or a community-based in-reach application assister. We've seen it all different ways; and that can be something that you say, "Look, we're going to serve all comers in terms of getting applications submitted." A state can say, "I'm doing an assessment. I've figured out what's happening in some facilities, and this is what they're doing. We're going to let them continue that. There are some facilities that are *not* establishing standardized enrollment processes, and this is where we want to partner, let's say, with community-based application assisters and do some matchmaking with a particular facility and a particular community-based application assister."

You can sort of like make it as mixy-matchy as you want, depending on what your needs are in the facility.

Now, for the suspension processes, there needs to be a data match between the correctional facility and the state. That can happen in a number of ways. It can be sort of a daily individual file transfer. It can be a batch file transfer at the end of the day. It could be sort of an automated data match between the facility and the state Medicaid agency. It can be sort of through a communication portal. There are a lot of ways

that we've seen states communicate between correctional facilities and state Medicaid agencies that a person has been incarcerated.

So match/match – okay, now this person's already enrolled in Medicaid. I'm going to suspend them. Or a correctional facility wants to see if this person's already enrolled in Medicaid, so they're looking at some sort of portal to understand what's happening. Then, of course there needs to be a process in place for conducting annual renewals or redeterminations if an inpatient is receiving inpatient care and then ongoing.

So just to say this is where we know states are the most far advanced. Even if you think you're – there are some states that are like, "I've got a real command of this." This is your sweet spot. You've really been working hard ever since perhaps you've expanded Medicaid to implement enrollments and suspension processes. So you come from a great place of foundation.

If you are a state that has it really good in some facilities and not yet in others, you might want to really think about starting *now* -- even if you haven't submitted a section 1115 waiver, starting now on providing technical assistance support for Medicaid eligibility and enrollment. In our experience working with states, this is something that's been happening for years; and that's been the reason why they then feel comfortable in pursuing. Or it's something that says, okay, in a couple of months I'm going to be pursuing a wavier; so I'm actually going to start my enrollment and suspension to work now because I know how foundational it is.

Now, this is Kinda talking. This is not CMS talking. But you may really want to consider legislative authority for making it mandatory for pre-release enrollment and suspension and of course issuing guidance. If you can absolutely do this without legislation – and of course every state has its own politics and its own processes for how to implement processes – but when you make it mandatory, you are automatically sort of setting the first step of saying, "We are expecting by *X* date, every facility is working with Medicaid agencies, Medicare agencies implementing it in every correctional facility." Then that helps you move forward with the next steps.

Then finally, thinking about putting out education and outreach programs and leveraging peer supports to highlight the importance of Medicaid. Even if you don't pursue an 1115 waiver, you should be thinking about making sure it's happening in all your correctional facilities; and no doubt you already have to be doing it for all youth correctional facilities.

Okay, let's go to the next slide.

Now we're going to talk about eligible populations. Okay, we talked about enrollment and suspension processes -- threshold matter; have to do it. We're going to shift to reentry services. We want to provide reentry services, a targeted set of services to individuals while they're an inmate before they're released. Who am I going to make eligible for these pre-release services?

Well, the guidance is extremely flexible to states. States can decide how they want to define their eligible populations. You can say, “All my Medicaid- and CHIP-eligible people who are currently enrolled or not yet enrolled who are incarcerated can be eligible for the demonstration.” So you can basically say if you are in a correctional facility, you can receive pre-release services. We’ll talk about correctional facilities for you, but you can sort of make it as broad as you want.”

You also have the flexibility to target a subset of the incarcerated population. You can say, “I’m just going to have, for now, or I’m going to for this part of my demonstration first start with a target population.” That can be people who have substance use disorder, people who have serious mental illness, people who have SUD and SMI, or people who have SUD, SMI, and a chronic condition. You can sort of also decide what your target population is based on the demonstration that you want to pursue for this initiative.

Most importantly – and we get this question a ton – it can be someone who is pre- or post-adjudication. In other words, it can be who has been sentenced and they are in prison and sometimes in jail; or it can be someone who is still waiting trial or still waiting their plea agreement, and they have not yet been sentenced. That is entirely up to you in terms of your definition for eligible populations.

So a couple of considerations as you’re defining the eligible populations. Let’s go to the next slide.

If you don’t establish eligibility criteria, it’s going to be easier for the correctional facility to say, “Yep, everybody’s in; everybody’s eligible for pre-release services.” So you’re sort of taking out an administrative step, if you will, for identifying eligible populations. You’re also increasing the number of people who could be eligible when you’re not kind of slicing and dicing and establishing a criteria. So that’s sort of on the one hand.

On the other hand, if you do want eligibility criteria because you’re saying, “I really want to do an initiative that’s focused. I have a SUD crisis, substance use disorder crisis; or I really want to zoom in on people with substance use disorder and serious mental illness,” then you have to be sure to define that criteria in detail and then establish a screening process. The correctional facility partner is the one that has to screen.

So let’s say you’re saying, “I’m doing it for people with a substance use disorder and a serious mental illness.” Well, that correctional facility has to be your partner in identifying John Smith has got a substance use disorder based on your eligible definition, and therefore John Smith is eligible for pre-release services, and I’m going to communicate that to the Medicaid agency. So that’s an important step that you have to build if you’re having a screened-in criteria.

It's really important that it’s likely that you want to leverage a correctional facility’s existing screening process and criteria because they of course serve people with substance use disorder and mental illness; but who they serve may be more narrow than who you’re trying to target in your initiative, and you might need to think about matching and then expanding and helping facilities figure out what the right screening process will look like.

Then finally, if you *are* having an eligibility criteria, that has to be a data transfer because that's data that needs to be communicated. It doesn't need to be like an automated process in the beginning. It can be sort of a good old Excel spreadsheet of matchy-matchy. But it really does need to be information that's communicated from the correctional facility to the Medicaid agency that John's eligible based on this criteria, and therefore let's go with trying to deliver pre-release services.

Okay, let's go to the next slide and just share with you a couple of examples of what states have gotten approval for and what states have pursued.

So California, as Terese said, has already gotten approval for its reentry initiative. They're doing criteria. They are doing people with mental illness, substance use disorder, chronic condition, somewhat people who have intellectual and developmental disabilities, people with traumatic brain injury, people with HIV/AIDS, pregnant or postpartum people without meeting SMI or SUD -- so a pretty broad set of criteria established for its adults. And all its youths in California are eligible. They do *not* have to have any conditions. There, sort of if you're a youth in a youth correctional facility, you're eligible.

Kentucky has a narrower proposal. It could change; but their proposal based on publicly-available information has a criteria that's focused on substance use disorder. That's where their initiative is zooming in on.

New York has a definition that's similar to California's, slightly pared down; and Washington is going with all Medicaid-eligible individuals. So you can see examples of states that have taken all different opportunities in defining their eligible criteria. Regardless of whether you use an eligibility criteria or not, you're going to have to have a way of communicating people that are receiving pre-release services to the Medicaid agency. The reason why is because a state needs to figure out how to limit the billing and claiming of services in that pre-release period only to their authorized services.

Now, some states establish an indicator or aid code that can track and limit that billing and claiming. A perfect example is if you run a Medicaid agency, you know that your family planning benefit program recipients receive a certain set of services versus your kids in Medicaid receive a certain set of services versus your adults in an alternative benefit plan receive others, right? Each person gets an aid code that allows services to be billed under that aid code.

Similarly, you're going to want to set something up like that for the inmate, the individual who's eligible for pre-release services. Of course, we want to make sure that your screening processes that you set up are designed to maximize the number of people who are eligible for pre-release services, minimizing the risk of individuals who have undiagnosed conditions getting services.

Okay, let's go to the next slide. I'm about a minute or two over, but I will catch up.

So eligible facilities – now, CMS in their guidance – again, maximum flexibility in defining facilities in which you will provide those pre-release services. So you can do state and/or local jails, prisons, and/or

youth correctional facilities. You can just do adults; you can just do youth; you can do a mix and match of across the facilities. You have the discretion to propose the types of carceral settings that are going to participate. Guidance is clear. Federal facilities are not eligible to participate in the reentry demonstration; but you should be figuring out a way to assist federal prisoners who are in your state with applying for Medicaid in the state in which they are going to be released.

Then finally, we get a lot of questions about halfway houses. You know, without it sort of being a red herring, just to sort of say the general rules -- and CMS has guidance on this -- is that individuals can receive Medicaid services and are not considered an inmate if they have freedom of movement. I always say like, “Can they go to the corner store and get milk?” That’s sort of like the test of are they allowed to go around and have movement and go to their jobs and then go to the corner store and then come back to the halfway house – in which case they are not an inmate, so they do not need pre-release services because they already are entitled to full-scope Medicaid if they’re eligible.

Just to say some examples, again similar, wide variation in how states have approached their eligible facilities. We can see here Washington is doing state prisons, jails, and youth correctional facilities – all the options. West Virginia is doing state prisons and regional jails; that’s in their proposed. Montana is just doing state prisons – they’re saying we’re a service prison, so we’ll see how it goes, and we’re going to look to jails. Illinois is going to do the reverse. They’re starting in their initiative proposal to do just the Cooke County jail and not just the huge jail.

Okay, let’s go to the next slide and just say some considerations.

So operationalizing in state prisons, I’d say, is relatively easier. The reason why is because we have a release date. We’re going to talk about release dates and how do you build 30 days from what date if the person doesn't have a release date. Prisons, we have a release date; so it’s much easier than working in establishing a time period. That should not discourage you from working with county jails, but it really is an important factor because you can back into it. John Smith is slated to leave on January 1 of 2024, so that I can back into 30 days prior – or 60 or 90, depending on your initiative – and that’s when I start the pre-release services.

Now, local jails and correctional facilities is a little bit more complex because we don’t have a release date; and the average length of stay is usually less than 30 days, and sometimes it can be 15 days. Now, that doesn't mean you shouldn't be providing services in local jails and correctional facilities because those are individuals that we know tend to have a cycle of release, hospitalization, and reincarceration. So we often think about implementing what we call a “short-term model,” which is saying we’re going to start when the person is at intake into a correctional facility. Then, because we know the average length of stay is less than 30 days, we can start getting the Medicaid enrollment application put in and then start delivering services to the extent that we can so at the *very* least, the person gets meds in hand. That’s a victory for someone who might not have gotten it had you not had that initiative.

Regardless of the facilities that you are operating, you may want to think again...can this begin at CMS on mandating correctional facility participation? That will help a lot. You might want to think about phasing an approach, just saying we’re going to start with prisons; and we’re going to start with these five jails. Or

we're going to start with jails, and then we're going to expand to prisons. Or we're going to start with one jail, like in Illinois; and then we're going to expand based on that. That's entirely up to you.

Most importantly, states are required to conduct a readiness assessment before *any* services can be provided; and we'll do more information as we talk a little bit further. I'm going to pause.

Terese, to you.

[Teresa DeCaro] Thank you, Kinda. We have just a couple minutes for questions. I'm looking for questions just in the Chat.

"For forensic hospitals conducting competency restoration, are our forensic hospitals" – I'm sorry, one moment please, "*"Are forensic hospitals conducting competency restoration eligible for this waiver?"*

I'm going to turn that to, I think, Sarah O'Conner or Sarah Harshman.

[Sarah O'Conner] This is Sarah O'Conner. I think we may have to take that one back.

[Teresa DeCaro] *"Does CMS allow states to phase in correctional facilities over time if prisons are ready first, then jails come along a year or two later?"*

I think, Kinda, you went over that; and the answer is, "Yes." Kinda, would you want to add anything more?

[Kinda Serafi] No, I just want to say it may behoove you to think about a phased-in approach. In your negotiations with CMS, you should sort of have a sense of how many facilities you're expecting to go in; and you really do want to have an outer bound timeline for when you are because it's a demonstration. You have to prove something. It can't just be like, oh, we're just doing this. You have to show that this is actually going to have an impact.

But if you want to have a phase in I think, Terese, CMS is entirely open to talking that through as an approach.

[Teresa DeCaro] I just want to take a moment to say we have a variety of subject matter experts on the phone. Generally at the moment, probably forensic institutions are not included; but we will circle back on that question.

"Has there been any additional indication on whether IMDs may be eligible?"

Kinda, can you take that?

[Kinda Serafi] I think it's the same idea as the forensics. I think at the moment the State Medicaid Director Letter is clear, states and local correctional facilities; and the guidance at this moment is not opened up to institutions of mental disease. We're just at the beginning of this journey – right, Terese – so we're starting there.

[Teresa DeCaro] Yes, thank you. I think that's the end of our Q&As, and I think, Kinda, we're ready to go to the next section, Services. You'll be talking about scope, delivery, billing, and claiming.

[Kinda Serafi] Okay, wonderful.

All right, so where are we?

We just talked about let's get everybody enrolled in Medicaid, and let's suspend them if they come in already enrolled in Medicaid. Then we talked about who's eligible for pre-release services. We talked about what facilities I can put the pre-release services. So now let's talk about the services. This is the heart – this is the meat of the whole initiative.

Let's go to the next slide.

So the State Medicaid Director Letter establishes a mandatory minimum core set of services, and it's threefold. The first is case management, and that goal is to address physical and behavioral health needs as well as health-related social needs. The second is to provide medication-assisted treatment, MAT treatment, that's clinically appropriate for both OUD and AUD, opioid use disorder and alcohol use disorder; and then, a 30-day supply of all prescription medications as clinically appropriate based on the medication.

So this is the three mandatory minimum. You can add more. We'll talk more about what you can add, but these are the core. You may not pursue an initiative unless you are providing these three. These are three biggies; there's no question. So first let's talk about case management.

Now, my current state assessment recommendation is just to sort of say when you are doing a survey and you're starting your interviews and you've begun to make really good friends with the sheriff and with the head of the Department of Corrections in your state, you're going to hear – and appropriately so – that many correctional facilities do some form of reentry case management to support individuals. They have a care plan; they give it to the person in hand. But the person then leaves, and then we have a disconnect.

So while some, but not all, facilities *do* some sort of reentry case management, what we're really trying to accomplish in this initiative is that continuity from the case management in the pre-release to the case management in the post-release because as Terese laid out in the demonstration objectives, we're trying to connect people to services in the post-release. We're trying to avoid hospitalizations and emergency room use. We're trying to connect people to behavioral health and physical health services. So that continuity is the goal here, and we'll do a little bit of a deeper dive on case management in a minute.

MAT is also something that you will see your correctional facilities are already providing in many cases, not all. I am confident not all, and there will not be one state that has it in all of their facilities. But there are a lot of states that have a really good set of work that has already happened using SAMHSA grants and state-funded grants, and other great combination of grants to provide MAT to individuals who are incarcerated. Now, the new requirement for MAT for both opioid use disorder and alcohol use disorder is likely going to require correctional facilities to maybe expand what they're currently offering and to make sure that the form of MAT that they're providing is consistent with the State Medicaid Director Letter. So this will be a place where you are augmenting, enhancing, and providing new when there isn't one.

Then finally, the 30-day supply of medications – similarly, some but not all facilities have some pharmacies on-site. What we've learned, which has been fascinating – I can't tell you how much I've now learned, understood the mail-in pharmacy provider industry for correctional facilities. Some facilities use them; some have facilities on-site; some use facility-based pharmacies that are right next door. You're going to have to sort of figure it out. Just like we were saying each facility might use its own separate Medicaid application process, each facility might have its own type of pharmacy that it provides.

So this is going to be a thing. Most correctional facilities definitely give scripts, but they don't definitely give meds. That's what I've learned is a big, new operational set. Now, we are telling you all this because we don't want to discourage you; but we just want to make sure you understand all the things that you're going to have to solve for as you're planning and designing.

Okay, let's go to the next slide.

I want to just spend a little bit of time to do a little bit of a deep dive on case management because in my humble opinion, I think this is the anchor service. I think to me, if you get someone who is doing – a care manager who is coming in, case manager who is building that bridge to post-release physical health and behavioral health and those health-related social needs, we are really in a much better spot than we were ever before having this initiative.

Now, it could be possible – and we'll talk a little bit about that pre-release care manager being different than the post-release care manager. I would hate that to be the case, but it's going to happen in some circumstances. If that's happening, then what you need to make sure is that there's a warm handoff where the post-release care manager – case manager – if I'm using those words interchangeably, forgive me – is meeting with the pre-release case manager with the person present so that this person, John Smith, can understand this is the person who is the post-release case manager, is there to support John Smith in getting his behavioral health treatment when he's released into the community.

Let's go to the next slide.

The guidance – I'll say this – the State Medicaid Director Letter is so strong in its detailed expectations of a pre-release care manager for the reentry initiative and *really* helps lay out the expectations for what a pre-release care manager should do. So you should, Step 1, take a really hard look at that State Medicaid Director Letter because it provides tremendous detail in what should be expected.

You should be thinking about having your own policy and operational guidance as a state Medicaid agency that's laying out those expectations for the pre- and the post-release case management for having – making sure that there's closed-loop referral -- if referrals for the pre-release care manager is making it to behavioral health providers, that there's follow-up with that referral, making sure there's smooth linkages to physical/behavioral health and health-related social needs, and then making sure that there's collaboration between all the case managers providing the pre-release case management and the provider in the post-release period.

Now, you're going to have to decide – and this is *hard* – who is going to be your case managers, who's your workforce. I'll tell you, it's not an easy thing because we've never had this before. You will find that the workforce that you might want to tap into – like your Medicaid managed care plans, for example – are great at case management. They might not be great at working with the justice-involved population, right? So that's sort of one thing.

You might have great community-based providers that are expert in working with the correctional facilities and doing pre-release case management, but they only do substance use disorder, let's say, or only do SMI; and the expectation is the full, whole-person case management. You have correctional facilities that could potentially do the case management and the pre-release, but they need to be really clearly connecting in the post-release because we cannot have business as usual.

So just thinking about all of the workforce issues that you'll need to implement to make sure that you have a robust workforce, and that's going to take time. This is something we really want you to spend time *now* thinking about, even if you haven't even started it (inaudible) is beginning to identify who the workforce is that's going to be helping John Smith and supporting his post-release.

Regardless of the model that you have, you're going to want those clear expectations in that pre- and that post-release period. So we've talked about the warm handoff. I don't need to repeat it, but you can tell I want to repeat it because it's so important.

Let's say that you do decide to do managed care plan to do the pre-release case management. If you do decide that – and that's, again, states have taken *wide* approaches on this – you're going to want to think about how do you get enrollment into the Medicaid managed care plan. Is it going to be the way they usually do it, which is a choice period and then auto assignment but times for that? Is it going to be something where you do auto assignment with a choice period, and how are you going to effectuate that auto assignment for people who are pre-released – inmates?

Then, communicating the information that John Smith now has been assigned to *X* plan. So *X* plan -- we're expecting you to come on Tuesdays and meet with John Smith via telehealth. So these are all the kinds of data exchanges that have to happen in terms of communicating that flow so that John Smith can meet with the pre-release care manager.

Then, if you are having the managed care plan play a role in the pre-release care management, you have to think about what contract requirement amendments you need to make. What do you need to put out in terms of policy guidance and clear expectations?

Okay, let's go to the next slide and talk about additional services.

So in addition to case management, MAT, and the meds in hand, the guidance is clear that you, as a state Medicaid agency, can offer additional services. For example, the guidance says you can offer family planning services and supplies. You can do services provided by peer supporters or community health workers with lived experience. You can do behavioral health rehab or preventive services or treatment for Hep-C.

Now, it's clear in the guidance that those services that you are providing *have* to be justified -- that they are connected to being effective in supporting the reentry into the community. We are not interested in using Medicaid dollars to pay for services that are just focused while the person is an inmate. The goal really is connecting the needs of the carceral population and justifying those services that the goal is to advance the Demonstrations initiative as a whole, which were all of the goals that Terese has laid out.

We wanted to just lay out what's been approved in California and Washington. This is not the limited set of services. We just wanted to show you examples; but of course, based on the justification, you can go beyond what those additional covered services are and beyond what Washington and California have approved, but you need to make the link.

So Washington and California got, in addition to MAT meds and meds in hand and case management, physical and behavioral health consultation. So case manager calls psychiatrist who's in the community and says, "I need a consult. Can you help me?" Then, the psychiatrist can get reimbursed for that consult. Laboratory and radiology to assist with MAT and meds. Medications during the pre-release period – so not just in-hand but during the time the person's incarcerated – durable medical equipment and community health workers.

Okay, let's go to the next slide.

When you think about who can provide the pre-release services, it can be in-reach community-based providers or/and correctional facility providers. So the goal – we're really trying to establish relationships in the post-release period, right? This is, again, not using Medicaid dollars to supplant correctional facility

dollars for while they're incarcerated but really looking to the support for the person when they're reentering the community. So of course an in-reach, pre-release provider is better because it's establishing that continuity of relationship when that person's released into the community.

But it can be that you have some combination, and we'll show you an example of what that could look like. Services can be provided in-person or via telehealth. If you are relying on correctional health providers to do the services, you need to make sure that those correctional facility providers are complying with your state Medicaid provider participation requirements as established in your state. This is – we'll talk about this later -- correctional facilities need to understand this isn't a grant program. If you want to get reimbursed for Medicaid services, you need to bill and claim consistent with the state Medicaid requirements.

Let's go to the next slide.

So in-reach community providers – you can leverage those community-based providers. I talked about establishing the continuity of care. What is important – and I mentioned this a little bit – is that you may have *really* ready and willing community-based providers who just don't have experience working in correctional environments. Like so for example, they don't have experience in addressing trauma or criminogenic race factors; so this might require additional training and support.

You're going to absolutely need to work with your correctional facility providers – facilities -- and I cannot hammer that enough here and throughout. They are your implementation partners. This will only work if they are there at the table working with you, rolling up their sleeves, shoulder to shoulder, for implementation. One of the most important things that they need to do is ensure security processes are established for providers who can come in in-person and have private interview rooms where they can interview the person and provide services. The case manager needs to feel safe in the correctional facility and needs to have a private space to be interviewing John Smith to build that trusting relationship.

We need to make sure that they're able to see their provider via telehealth or in-person. They *have* to be your partners on this. Part of this is understanding what's currently happening in the correctional facility *now* with respect to the delivery of services. For example, if you're delivering MAT as a mandatory minimum service, you are going to want to know is MAT being offered by a correctional facility, or is it being offered by an in-reach community-based provider. If it's being provided by in-reach community-based providers, they're already enrolled in Medicaid or they should. If it's being provided by a correctional facility provider and they want to get reimbursed from that, they're going to need to enroll in Medicaid. So you need to sort of – part of your diagnostic is figuring out what's happening now so that you can help direct what will happen in the future.

Okay, let's go to the next slide.

I've mentioned this but billing and claiming is really critical here, right? So you first have to decide if the delivery service for your services. Let's say you're doing the mandatory three plus you're doing clinical consultation. So you're doing case management, MAT, meds in hand, and clinical consultation. Are you going to do that through a fee-for-service? Are you going to do that through a skinny capitated payment

rate to a managed care plan? Are you going to do a combination? That's sort of Step 1 in thinking that through.

Step 2 is rates. Like this is, oh okay, how are we going to pay you for the services? Are you going to use your standardized service rates that you have for your Medicaid right now? Are you going to think about incentivizing in-reach providers to do in-reach services and therefore you're going to give tiered rates for those in-reach providers as compared to correctional facilities providing those services because it's harder to get into a correctional facility and deliver services? Are you going to do some sort of bundled payments for care management to incentivize requirements related to care management, care plans, and needs assessments and post-release? Are you going to do a combination? So this is like some interesting work that needs to happen in terms of reimbursing for the services that you want to provide in the pre-release period.

Important, correctional facilities don't have any experience for the vast majority. Someone is going to say, "No, mine does." It's varying types. It's possible that they do; but generally, they do not have experience billing for Medicaid. They have electronic health records, but they don't have the sort of tab that goes with the electronic health records that allows you to bill and claim for Medicaid. It's going to have to be a whole sort of infrastructure that has to be stood up in a correctional facility – new operational processes, new technical assistance.

I've worked in states where I've had prison systems on webinars with the state Medicaid agency's billing and claiming team. They are teaching them. This is how you enroll in Medicaid. This is how you bill claims. This is a CPT code. They're sort of just rolling up their sleeves and helping them understand what has to happen to do billing and claiming.

Let's go to the next slide.

I'm going to just give you an example, example, example – underlined, bold – of what these different managed training minimum services could look like based on who provides the service and who can bill. This is example, example, example.

Okay, so case management – let's say this example state is saying, "I'm going to use in-reach case management through my Medicaid managed care." That's going to be their workforce approach. So the case manager will be enrolled as the Medicaid provider and get paid via the managed care plan. That could be an example of how that works.

Now, they could say, "Oh, I've done an assessment; and I understand my facilities. Actually some already use correctional facility providers or they're providing MAT. The facilities that don't, we're going to set up a partnership with in-reach community-based providers." So you could sort of have a combo, in which case that would be your workforce solution. Then, your billing and claiming would be both the in-reach and the correctional facility would both be enrolled as Medicaid providers and bill the Medicaid agency.

Then similarly, the 30-day supply -- states can leverage their existing correctional facility pharmacies if that facility has it. Those facilities have to enroll as Medicaid pharmacy in order to bill and claim for the meds, or they can use the community-based pharmacy that's around the corner or the mail-in pharmacy. Those mail-in pharmacy or the community-based pharmacy will need to enroll as the Medicaid provider.

So we just wanted to give you an example of an analysis and how this would work. Once you've honed in on your services and you've done more work on your current-state assessment, this is how you think about who's going to provide those services and how am I going to have them bill and claim for the services.

Okay, let's go to the next slide.

Pre-release time frame – I know I'm a few minutes over, but I'm going to catch us up, I promise.

So for the requirements by the guidance CMS has said that generally for the reentry, you're expected to cover the pre-release services beginning 30 days prior to the individual's expected date of release. Pause – I know it's hard; I'm going to come back to it.

CMS can and will consider approving demonstration authority for coverage for up to 90 days prior to the pre-release period, and they already have in California and Washington based on their proved demonstrations. If you are going beyond the 30 days and you're doing a California and Washington, there is an extra expectation as part of your evaluation that you have to evaluate the novel hypothesis that says why a longer time frame is better for my initiative. I need more time, and this is the way I'm impacted. I'm trying to evaluate whether the longer period of time is going to help it be more meaningful in the post-release period.

Example evaluation – so first, understanding generally the average length of stay in correctional facilities. This is generally public information, right? You've got a team of staff that has googled this a gazillion times for me, and you can find out how long people stay in prisons, how long people stay in your correctional facilities, in the youth correctional facilities, and your jails or regional jails.

Generally, and not pushing one way or the other but just time is time – so more time lets you have more time to set up pre-release services. So 90 days gives you a little bit more of a runway. But just understanding that 90 days is only really going to be helpful in prisons because that's when people stay longer because most individuals in jails and youth correctional facilities, as we talked about, have a shorter length of stay, 30 days; and they have unpredictable release dates.

So let's say that you have a person who comes in and they are in a jail and you do my short-term model that I love where you start delivering Medicaid. You make sure they're enrolled in Medicaid, and then you try to get a care manager as soon as close to intake, let's say within 10 days. If maybe all they do is set one meeting with the care manager and then they're released after 15 or 20 days, that's pretty great because then they'll also hopefully have the meds in hand. So understanding that even people in jails,

you can manage your expectations of how many services. You might not be able to find a full suite of services for a short-term stay, but at least you can get the ball rolling.

Then really talking about that short-term model and getting your correctional facilities onboard with this idea that, yes, we don't know the release date; but that does not mean that we can't provide services. We just have to sort of start when the time of the person comes in as opposed to in a prison when we know the person is being released.

Okay, let's go to the next slide.

Ah, all right, back to you, Terese.

[Teresa DeCaro] Thanks very much, Kinda. I see one question in Chat concerning reporting requirements, and we'll be talking about that in a few minutes. Are there any other questions? We'll give this just a moment.

[Pause]

Okay, we have a question about elements of the care plan: You know, Kinda, because you have been talking to states, would you like to focus on this for a moment; and then we can move on to the next section?

[Kinda Serafi] Sure, sure.

So again, I'd definitely refer you to look at the State Medicaid Director Letter, which is linked in the slides; but it absolutely *must* include physical health, behavioral health, and health-related social needs. Even if you are a state that is just doing substance use disorder, for example – you know, we talked about the eligibility criteria, and you're just treating people with substance use disorder. The care plan can't just be limited to substance use disorder. You are treating the whole person. So even if you're targeting people who have substance use disorder, they're eligible for pre-release services, that care plan needs to look at the whole person and help them connect to all the services – physical, behavioral health, and health-related social needs.

That's going to be something that's required of you in your special terms and conditions of your reentry waiver, and also you'll see that in the implementation plan requirements.

[Teresa DeCaro] Okay.

'What if you start the services pre adjudication and then they end up with a longer stay than maybe what they'll pay for those prerelease services?

We've talked about this, Kinda; I'll leave this to you too.

[Kinda Serafi] Yeah, so this is really a good question; and I want more of those questions because I know this is complex. I know you all have questions about this, so you should just ask all of those.

So let's say you have started an intake, and the average length of stay is 30 days. There should be nothing – you have, let's say, 90 days in your initiative. So I'm going to be a little cheaty on this scenario, and you start average length of stay 30 days. Person stays in, but then their trial gets pushed out and it gets pushed out and it gets pushed out. The expectation is that you are tracking that 90 days, and you are stopping the services. The guidance is pretty clear that it cannot exceed 90 days.

So there is sort of an element of working closely with your correctional facilities to make sure that we're stopping at a certain time period that would allow a clock resetting before the person's released to make sure that that reentry is happening pretty smoothly. But that is a complication, and it happens. What I try not to do is to solve only for the edge cases, but that's definitely a scenario that could happen.

[Teresa DeCaro] Right. Kinda, I think we should go to the next section. You'll be talking about reinvestment plans, readiness assessments, implementation plans, and monitoring and evaluation.

[Kinda Serafi] Okay, great, thank you.

Let's go. You guys have hung in, so we're doing great. Let's go to reinvestment plans. So what is the requirement in the guidance?

Guidance is *very* clear. Condition of receiving approval is that you are expected to reinvest any federal dollars that are being invested that are replacing the cost of existing health care services, so services that are currently being paid for by state or local dollars in a correctional facility. If there are federal dollars that are coming in and replacing that, the expectation is that you are reinvesting those dollars. The reinvestments are pretty flexible in the guidance, and they can support improved access and quality of health care and health-related social services for those who are incarcerated or recently released. So it's very flexible and broad in terms of how you can use those dollars for reinvestment.

The whole point of this – we've said this a couple times, we'll say it one more time – is the reinvestment in carceral health care should supplement and should not supplant existing state or local spending. So how does it work?

It's basically your reinvestment has to specify – it's going to be in your special terms and conditions that will be due a certain number of days after your waiver gets approved, a certain number of months – and it has to specify the amount of federal matching dollars that are being funded in correctional facilities that you're replacing. You have to describe your reinvestment, like what am I going to use to reinvest – like where am I using those dollars into reinvesting what? So access to behavioral health and physical health services, for example, or improved health information technology or improving increased community-based provider capacity to come in and do more in-reach. These are all examples of reinvestment.

An extremely important point though is that the dollars that you pay as a state to pay for your new services or your enhanced services or your investment funds can count as part of your reinvestment. So in other words, let's say that you are offering in your pre-release package medications during the pre-release period. Medications are already being provided in a correctional facility. Those are dollars that are already being used state and local. Those are dollars you have to reinvest. However, the dollars that you are already paying for your *new* services – like case management, like community health workers, like clinical consultation, like durable medical equipment – the state's share of those can count towards the reinvestment that you are putting in for the services that you're replacing.

The most important – not the most important but a very important point on the reinvestment is that CMS is not going to approve a plan that says that funds are going to be used to build prisons, jails, or other correctional facilities. It can only be used for -- and it cannot be used for non-health-related improvements in those facilities or increasing the profits of private carceral facilities. All of this should go without saying, but it's important to note.

Okay, let's go to the next slide.

Now, here's the story. We've talked about correctional facilities as being your implementation partners, and they are key here in making this all work. You're going to find some correctional facilities are all-in. They're probably the ones who have been sharing with you the California-approved waiver and the state Medicaid director guidance and saying, "Can we do this? We want to do this."

There will be other correctional facilities that will be like, "I don't want to do this. I'm swamped! I don't have a workforce. Things are really hard right now. I've got to protect and secure. I don't have time to do this kind of initiative."

Okay, so you're saying correctional facilities have to do this; and you're now putting in Medicaid dollars to implement these services and in some cases requiring that correctional facilities can bill Medicaid dollars. You need to make sure they are ready to do so. So there is requirement in the state STCs of when you get approval. There's requirement in your implementation plan to describe what is your plan to say and check with your clipboard that the facility is ready to implement those services.

I'm not going to read all these bullets. You get the slides later. But the bottom line is you're asking those facilities, "How are you screening people for enrollment in Medicaid? Who are you using to enroll people in Medicaid? What's the suspension process? Who on the staff is doing the suspension process? How are you screening? Who's going to be screening? At what frequency are you going to be screening?"

You're going to be asking the weedy, weedy operational requirements of your initiative to make sure that your implementation partners are doing this right and that they have been deemed ready by you, state Medicaid agency, to start implementing this initiative.

Let's go to the next slide.

So you want to think about laying out as soon as you can your expectations for your readiness assessment. So what I've seen work -- and you don't have to follow this playbook, but it is a good playbook – is you sort of number one, get your waiver approved. Number two, get your implementation plan sorted. That's a requirement, and we'll talk about that in a minute. Number three, you should be meeting all along with your correctional facility and other implementation partners.

Before, you should be thinking about putting guidance that says, "These are my expectations for my initiative." Then, you say, "Okay, here's my expectations. Now here's what I'm expecting to have you say that you're ready." So you sort of lay out, if you will, all the steps that the correctional facility has to abide by when it comes to being ready.

So even if none of your services are being offered by a correctional facility – so let's say you're doing in-reach case management and in-reach MAT, and the meds in hand is a community-based pharmacy. You still need to make sure the correctional facility is *facilitating* the delivery of those services. So, "Tell me where's your telehealth space? Tell me how you're going to let the case manager come in – on what days? What's the process that they have to do to get the telehealth set up?" So all of the things that go with running a health care program, a health care initiative, in a correctional facility.

We want to just make sure that you think about establishing enough time -- you know, how much time. Let's say you want to go live on July of 2025. You probably, by January of 2025, should be laying out all the expectations for readiness and putting out a readiness assessment tool and getting your clipboard out and talking to the correctional facility and having them share with you, in writing, with their processes and their process flows, how they're going to operationalize their readiness.

Okay, let's go to the next slide.

I've mentioned the implementation plan. This is a *really* important step in this process because we love this initiative, and I loved it three or four years ago when we were cooking this all up and trying to conceive it up in various states. Then, the rubber hit the road and we tried implementing it. We're like, "Oh my goodness, this is hard."

So an implementation plan helps tremendously. It's a required post-waiver approval document, and it basically lays out – the state will lay out for CMS, but it's a really good exercise on the state's perspective in on explaining how are – what are your specific design elements when it comes to the policy and the operational processes for ensuring continuity of coverage for people who are incarcerated, for covering

and ensuring access to the services, for promoting continuity of care, for connecting services to the post-release, and for ensuring host system collaboration.

The implementation plan – the requirements in the State Medicaid Director Letter are pretty clear in terms of implementation plan expectations. In my book, I think it helps organize you. I mean, it's not exclusive. It's not exhaustive on all the pieces that you have to think about for implementing it, but it sure gets you started on getting the juices flowing on how you're going to implement all of this. Then, it becomes a document you send to CMS and CMS reviews; and then they fully understand how you are operationalizing the initiative.

Okay, monitoring – to answer the other question – so states are going to be required to conduct a quarterly and annual monitoring, just like with any other demonstration. It's sort of – this is not one of those that we're not going to have ongoing monitoring. Now, the monitoring metrics that the guidance requires say at a minimum – and so there could be more – but at a minimum, you're going to be tracking the administration of screenings to identify people who are eligible for pre-release services, the number of participating pre-release service providers, the utilization of services – so how many people use MAT, how many people had meds in hand, how many people had a care manager, and then how many people got access to post-release behavioral health and physical health services?

The provision of those services pre-release, the number of people who got a care plan at release, the uptake of any data system enhancements, and the quality of care and health outcomes. For example, and especially those related to disparity-sensitive measures, any of those related to ED use and ER use. CMS is going to be working with states on their monitoring protocols and providing more detailed guidance than is already in the State Medicaid Director Letter, but there will be an expectation for this.

Let's go to the next slide.

Then just like in any other demonstration, you will need to conduct a robust evaluation of your demonstration. There's nothing new here. These are just sort of bread and butter components of a demo. The evaluation is going to test whether that demonstration expands Medicaid coverage through increased enrollment and increased access to those high-quality pre-release services so that we are supporting the post-release upon reentry.

So outcomes of interest, as laid out in the guidance, include cross-system communication; connections between the correctional facility and community services; the provision of preventive and routine physical and behavioral health services; and the avoidable ED and inpatient hospitalization. Part of the evaluation, states should conduct a comprehensive cost analysis to estimate the cost of implementing the demo. You should be collecting data that supports analysis that's stratified by population. To the extent you can stratify it by youth, by adults, by pregnant people, by MAGI, by non-MAGI – that will all be very helpful in understanding access to -- and also by race and ethnicity of import -- will all be able to help you understand how much you're demo is impacting various populations.

Again, as we talked about, if you're going beyond those 30 days, you need to demonstrate those additional hypotheses on testing the additional time for adding more time to connecting people to services.

Okay, I'm pausing and passing.

[Teresa DeCaro] Thank you, Kinda.

If folks have questions on this section, by all means please send them in.

There is one question here that asks whether a prison can opt out. I think the answer to that question is it really depends on the state Medicaid agency as to what that requirement will be.

Another question here: "*The Consolidated Appropriations Act of 2023 that requires eligible juveniles who are within 30 days of release, some are public institutions and receive targeted case management."* You spent time on this, Kinda. *Let's see: "How will the requirements be expected to intersect the 1115 Waiver guidelines?*

I think the expectation is that those *be* met. Then, Kinda, would you add anything? I mean, you did talk about this earlier.

[Kinda Serafi] My theory of the cases -- you're rightly pointing out that the Consolidated Appropriations Act is requiring case management for youth and youth correctional facilities who are post-sentenced. To me, it's like, oh, you're going to have to do this anyway. You're going to do this for youth, and you're going to have to do this in youth correctional facilities. So to me, that's a little bit of an incentive for this demonstration authority because you're going to be implementing it. So you may as well sort of think about whether you want to expand it to other facilities and add those other services.

But I think at a minimum, there will be a dovetail, right? So if you already have a demonstration and you're already covering youth correctional facilities and you have to provide case management, then you will be for the most part in compliance with the Consolidated Appropriations Act pending additional guidance that I know CMS is going to be putting out on this.

[Teresa DeCaro] Kinda, we have a question here; and I'm going to ask you to expand on the experience that you've had with states so far: "*What is a reasonable time to expect from planning the implementation?*" That is a complex question. What can you say about it?

[Kinda Serafi] It's a great question.

Okay, if you're a state that hasn't yet started an initiative – has not submitted a demonstration -- start now. Just start with the Medicaid enrollment. Start with the surveying. State with the current-state assessment. Really understand the lay of the land. Understand who your correctional facility partners are and what you want to do and where you want to do it.

When you are then in the negotiation – let's say you submitted a waiver and you are negotiating with CMS. You should be planning. You should be thinking. As long as you're in alignment with the State Medicaid Director Letter and with the California and Washington's STCs, it's a matter of time to getting approval; but time should be happening now. Like this is wasted time for you if you're not meeting with your facility partners and understanding what's happening.

Once you get approval, it depends then how much time you've been planning. If you've not done any planning and you've got approval, it's going to take time. It's going to take, I mean, no less than a year; and 18 months is usually my timeline if you want to be safe because there are system changes that have to happen. The IT systems is what kills you in terms of planning.

But if you've been planning for two years and then you got waiver approval, you can do it in probably under a year; and you could go live. You definitely need to get your implementation plan in. You have to do your readiness assessments. You've got to put out guidance. You've got to be sitting around the table. But you could start.

Or you could even just say – and then I'll shut up – maybe there's one facility that's like been your partner. They are like the go-to facility. They're the ones who are like, "Let's just do this." You could start with them within six to nine months after you get approval, so long as you got approval on your implementation plan because federal dollars don't flow until they get approval on the implementation plan. But once you get that, you can go; and then you can phase in the rest of the facilities.

[Teresa DeCaro] Thank you, Kinda. I think we should go to the next section, which is – and listen to what you're saying – supporting internal and external partnerships, infrastructure building, and IT system financing.

[Kinda Serafi] Okay, terrific. So let's go to the next slide.

Now, I've been a practicing attorney for 20-plus years. I've been doing Medicaid work for 15 years, and I've never done anything more complex in my career. I say this only because it is one of these unique initiatives that touches every single aspect of the Medicaid program. That's what makes it so complex. Well, there's other reasons; but that's a big one.

So I do want to emphasize that if you are one of the 80-plus, 90 people, who are on this call, you need to be thinking who else within your Medicaid agency should be thinking about this with you as your thought

partner because this initiative crosses eligibility and enrollment – remember, enrollment suspension. It crosses benefit design – we talked about it; provider enrollment teams, pharmacy and billing and claiming, provider billing and claiming, pharmacy billing and claiming, rate-setting teams, Medicaid managed care delivery teams. If you are like any state Medicaid agency, unless you're a very small one, these folks live in different offices all over the state Medicaid agency and you've got to bring them all together because this initiative crosses over.

This is a really important point of engaging your internal partners as soon as you can around this. You are going to want to have some sort of intra agency coordination and communication as soon as possible. So let's say that you want to have like a core team that's set up of this group of people. You don't need to have them meet every week; but you want a sort of person who's responsible that's implementing, and they're bringing in their subject matter experts. But you also want to be communicating to your Medicaid agency partners what's going on because when they're out in the field, they're going to be asked questions around the initiative; and you're going to want to make sure that they're feeling as engaged as possible.

Let's go to the next slide.

I want to talk about correctional facility partners. I think I've said it a gazillion times; I've made my point. But your correctional facility partners are your best friends here, and they are going to act like they're not your best friends; but you need to make them your best friends. You do. It's got to be day in/day out communication with them. They need to understand Medicaid; they won't. It feels new and scary to them. They will feel very intimidated by it, and you need to just make it safe for them to understand what's expected of them.

Go on a correctional facility tour. Go to a prison. Go to a jail. It's really critical. I had some brilliant ideas in the beginning of what we could do; and then I saw, oh, I see, this is how the flow works. This is where people need to move. This is where you could do the telehealth. I had sort of new idea and understanding of what it means because I physically went into a correctional facility. Then, I had compassion because I understood, A, the population we're trying to serve in a much deeper, better way; but also I understood the security restrictions that facilities also oftentimes have. You need to meet that with compassion and understanding too.

So please make sure that you really go to a facility and you hold their facility partners' hands in understanding program requirements.

You also need to find some champions. There's always one or two great sheriffs who are all about this, and they will rally the troops amongst the other ones if you're doing this within jails.

Then also, MOUs – memorandums of understanding – between states and correctional facilities. Those take time. You don't need one in order to go live. This might be something you think about long term, but it helps really clearly establish expectations on roles and responsibilities.

Okay, let's go to the last suite of slides.

Now, your external partners – let's put aside your prison, jail, and youth correctional facilities. Your external partners are going to be so hungry for this initiative. There is no doubt that your community-based organizations, your advocates, your providers, are going to want to do this; and they're really going to be like, "Let's do this; this is really exciting." Then, they're not going to really understand how hard this is because they haven't sat in on this webinar; and you're going to need to keep them along and sort of teaching them to be patient and give you grace as you are trying to plan and implement it. But you should start sooner than later.

If you have a demo that you've already submitted, you should think about a quarterly advisory group of external stakeholders that you're bringing to the table to sort of think about what are the issues. They're going to tell you six ways, "Oh, we don't have a release date."

You can say, "Well, that's okay. We're going to do a short-term model, and we're going to figure it out."

But you need to get them at the table so their voices are heard. You should think about who your workforce is going to be for your pre-release care management, and they need to be brought at the table soon and early. Consumer advocates – and I cannot underscore the importance of individuals with lived experience. We, in one or two states, have every six months brought individuals with lived experience who have opened our eyes on what will be effective and helpful in getting people to participate in the initiative who are inmates.

So please, please, include as broad a group of stakeholders – and you don't need to meet with them all at the same time. You can sort of have quarterly and then do these targeted meetings where you're saying, like, "I really want to do it this way." Then you could have a meeting with just a cohort of jails and be like, "Is this reasonable? What do you think of this time frame?" You sort of use them as your thought partners. But do not build this in a vacuum. That's a number one takeaway here.

Okay, and then let's go to infrastructure and IT system financing.

So one component of the waiver that you may get per the guidance is approval for transitional nonservice expenditures. This is time-limited support in FFP for new expenditures to help stand up the initiative. It will be *great* to your correctional facility providers to say, "We will have infrastructure funds for you to set up billing and claiming services and for you to sit around the table and build up your workforce." It's one-time; it's time-limited; it's standup costs. It's not ongoing, but it will have a *huge* impact in helping correctional facilities and community-based providers ready themselves to participate in your reentry initiative.

It will be beholden on you to define who are eligible for those pre-release services, what are the services and activities that are eligible for the dollars for getting these nonservice expenditures. And you're going to have to think about like, "Am I going to do an application process? How much time do I need to put out the application process? I have to do a review process. I have to do a granting process. Am *I* going to do

this? Am I going to get a third-party vendor for this process?" All these pieces of how you put out dollars – the same way that you do it now will have to take into account.

And just communicating to the correctional facilities that this could potentially be dollars that are available in helping them help you estimate the cost and how much it's going to cost for hiring staff, building IT systems, and developing protocols.

Okay, let's go to the next slide.

The guidance is really clear, and we just want to make sure that this is in front of you that Medicaid agency IT systems costs are also eligible for enhanced FFP. So first is the one-shot start-up costs. But this is sort of thinking about on the Medicaid agency side available enhanced FMAP for IT systems, and it can be to support data sharing between the Medicaid and the correctional facilities and other sort of systems like if you're doing auto plan assignment and you have to have new changes. That's also eligible for 9010. So that's very clearly laid out in the state Medicaid director guidance, but we just want to make sure that's on your radar.

Okay, let's see. Next, great -- Terese?

[Teresa DeCaro] All right, thank you.

I want to turn to Andrea Casart, who is in our state demonstrations, that group, is the director overseeing our policy work and implementation demonstrations.

Andrea, there's two questions here. One has to do with the implementation plan and whether there can be capacity building planning done before the implementation plan. Then can you also speak to current demonstrations as to whether or not they can be leveraged if a state wants to implement a reentry demonstration?

[Andrea Casart] Sure, so I'll answer the second one first. The state can choose to submit an amendment to execute this opportunity to an existing demonstration, and the implementation plan needs to be approved before FFP for services are made available. You can get implementation assistance without the implementation plan being approved.

[Teresa DeCaro] Thank you, Andrea.

I am looking for additional questions.

[Pause]

Okay, so I think we've got four minutes before the end of our webinar.

Kinda, I just want to thank you again. I think your work in this area is extraordinarily helpful, and we thank you so much for spending your time helping us help all the states understand what this terrific opportunity is. Did you want to have any parting word before I close out the webinar?

[Kinda Serafi] Yes, it's just, "Yes, we can on this," is what I expect all the teams that I work with say because you're going to get a lot of resistance, and this is hard. But you can do this. Just give yourself time. Plan it out. CMS is your partner are this, and you'll be able to do this it with us. It's new! We've never done something like this before, so that's what makes it exciting and hard but wonderful. We wish you all the best of luck on it.

[Teresa DeCaro] Thank you for that, Kinda. I want to say that you are also reflecting CMS's position on this to be sure.

I think this concludes our webinar. A couple of points – there will be, immediately as the webinar ends, a post event survey that comes up on your screen. It's just a few questions. It should only take you a couple of minutes. Please complete that.

It has been provided in the Chat and we can do it again – a link to the materials for this webinar. Then also in the next few days, we'll be posting under the Medicaid and CHIP Coverage Learning Collaborative the slides for this presentation.

With that, I bid you all farewell. Thank you so much for your participation. We hope that this has been both informative and encouraging. It's just such an incredibly important opportunity. Good night.